STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA EASTLAKE TERRACE	3109 EAST BRISTOL ELKHART, IN46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure survey. Survey dates: April 25, 26, 2011. Facility Number: 010065 Provider Number: 010065 Survey Team: Carol Miller, RN TC Mavis Stob, RN Honey Kuhn, RN (April 25, 2011) Census bed type: Residential: 75 Total: 75 Census payor type: Other: 75 Total: 75 Sample: 7 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 4-27-11 Cathy Emswiller RN	R0000	INTRODUCTORY STATEMENT:The preparation and submission of this Plan of Correction by the community does not constitute nor shall it be deemed to constitute an admission of fault or liability on the part of the community nor agreement by the community as to the truth or accuracy of the facts alleged or the conclusions drawn in the Statement of Deficiencies. The community prepared and submitted this Plan of Correction in order to duly comply with State regulations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0216	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on review of records and interview, the facility failed to ensure evaluations were accurate in regard to oxygen use and diet for 1 of 1 resident reviewed for oxygen use and 1 of 5 residents reviewed for diet in a sample of 7. (Resident #36) Findings include: During the entrance tour on 4/25/11 at 10:30 A.M., an oxygen in use sign was observed on the door post of Resident #36's room and an oxygen concentrator was observed in the room. The clinical record of Resident #36 was reviewed on 4/25/11 at 11:00 A.M., and indicated diagnoses which included, but were not limited to, Parkinson's disease and chronic renal failure with dialysis. Physician orders dated 4/16/10 indicated	R0216	A detailed audit will be conducted on all resident charts to ensure proper documentatin and accuracy between electronic and paper documents including, but not limited to:1) The resident's physical, congitive, and mental status.2) The resident's independence in the activities of daily living.3) The resident's weight taken on admission and semi-annually thereafter.4) If applicable, the resident's ability to self-administer medications.(d) The evaluation shall be documented in writing and kept in the facility.These records will be audited on a monthly basis to maintain accuracy.The Food Services Director will be provided with documentation as to the needs of a renal diet. Re-education will also be conducted with the dietician for a complete understanding of this diet and its importance.Food	06/30/2011

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	the resident could use oxygen as needed. Review of the" Resident Functional Needs Assessments" , dated 1/14/11 and 3/31/11, indicated under the heading additional needs "does not have oxygen". Physician orders, dated 3/8/11 indicated the resident was to be provided a renal diet. Review of the Resident Functional Needs Assessment, dated 3/31/11, indicated under the heading Functional Capabilities, "does not require special diet". On 4/26/11 at 10:15 A.M., Resident #36 was interviewed in regard to receiving information about his diet. He indicated he probably had been told something but he just ate whatever he wanted.		service staff will remind the resident of the importance of compliance with this order of dietary restrictions by the physician.	
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on review of records and interview, the facility failed to ensure clinical records were accurately documented in regard to inaccurate and missing information in the Resident notes. This	R0349	During the audit of resident records (R0216) all documents will be placed in chronological order.Resident #36 has been re-educated to notify the community when leaving the premises when ill so that proper	06/30/2011

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	deficiency affected 2 of 7 residents whose records were reviewed for accuracy, in a sample of 7. (Residents #36 and closed record #81) Findings include: 1. The clinical record of Resident #36 was reviewed on 4/25/11 at 11:00 A.M., and indicated an admission date of 9/30/09 and diagnoses which included but were not limited to Parkinson's disease and chronic renal failure with dialysis. Documentation in the Resident Notes, dated 3/8/11, indicated "res back form (name) hospital, o nos (no new orders)". The previous note was dated 12/22/10. There was no information when or why the resident went to the hospital. During interview on 4/26/11 at 9:30 A.M., with the Administrator present, QMA #1 (Qualified Medication Assistant) indicated the resident often would call a friend and would leave without notifying anyone and she did not know why he went to the hospital at this time. A hospital transfer form, dated 3/8/11, indicated the resident had been admitted to the hospital on 3/7/11 and discharged		documentation can be completed at that time.All physician orders will be reviewed by the Resident Services Director, or their designee, upon return from all hospitalizations.The Food Service Department will be provided with updated records, on a monthly basis, for all resident dietary requirement. This will be provided immediately upon all changes from a physician.Resident #81 no longer resides in the community. Notice will be published in the July 2011 newsletter reminding all families of the importance of notifying the community when taking a resident out to the hospital or physician to accurately chart changes to resident's condition/care.All nursing staff re-educated on the importance of accurate verification of chart when noting resident information.	

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	on 3/8/11. Medication orders from the hospital included an order for Xanax 0.25 mg (milligrams) (a medication for anxiety) to be given daily as needed. Review of the March and April 2011 MARS (medication administration records) indicated the new order had not been transcribed and the previous order, dated 12/7/10, was still documented. This order was for Xanax 0.25 mg to be given twice a day as needed. Review of the March and April 2011 MARS indicated the resident had only received the xanax once a day when required. The hospital transfer form, dated 3/8/11, indicated the resident should be on a renal diet. During interview on 4/26/11 at 1:20 P.M., the Dietary Manager was queried in regard to special diets. The Dietary Manager indicated the nurse would notify her of any special diets and a list was in the kitchen for dietary staff to follow. The list indicated Resident #36 was on an NAS diet (no added salt diet). The Dietary Manager indicated she was not aware of the order for the renal diet. 2. The closed clinical record of Resident #81 was reviewed on 4/25/11 at 2:45 P.M., and indicated diagnoses which included, but were not limited to, history			

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	of CVA (cerebral vascular accident-stroke) and dementia. Documentation in the Resident Notes, dated 10/3/10, no time listed, indicated the resident fell in the bathroom with no injuries. The physician and the family were notified. The next note was dated 10/3/10 at 6:00 P.M., and indicated "(hospital name) notified us resident fractured hip." The next note was dated 11/2/10, with no connection to the previous note. During interview on 4/26/11 at 9:30 A.M., with the Administrator present, QMA #1 who had written the notes, was asked to clarify the situation. The QMA #1 indicated the family had probably taken the resident to the hospital without notifying staff. There was no further information in the clinical record in regard to a fractured hip and the resident continued to ambulate in the facility. During interview on 4/26/11 at 10:30 A.M., the Administrator provided information which indicated the documentation regarding the hospital call and the fractured hip was written in error on the record of Resident #81.			